TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF PLANO

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-18-0778-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted an appeal as we show the 74177 and 99285 are not bundled per the NCCI edits . . ."

Amount in Dispute: $1,488.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider was properly reimbursed. The Carrier denied reimbursement on the basis that the reimbursement for the testing and visit are included in reimbursement for the primary service rendered, CPT code 49561 . . . "

Response Submitted by: Constitution State Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 1, 2017 to March 2, 2017	Outpatient Hospital Services Procedure Codes: 74177, 49561, 99285	$1,488.89	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 4915 – THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.

- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED
- 974 – THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 74177 has status indicator Q3, denoting conditionally packaged codes. Reimbursement is packaged with payment for the primary J1 status procedure billed on the same claim. Please see Medicare Claims Processing Manual Chapter 4 §10.2.3 for more details. Separate payment is not recommended.
   - Procedure code 49561 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This is assigned APC 5341. The OPPS Addendum A rate is $2,862.74, which is multiplied by 60% for an unadjusted labor-related amount of $1,717.64, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $1,682.26. The non-labor related portion is 40% of the APC rate, or $1,145.10. The sum of the labor and non-labor portions is $2,827.36. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $2,827.36 is multiplied by 200% for a MAR of $5,654.72.
   - Procedure code 99285 is packaged due to Medicare policy regarding comprehensive APCs. Reimbursement is packaged with payment for the primary J1 status procedure code 49561 billed on this same claim. Please see Medicare Claims Processing Manual Chapter 4 §10.2.3 for more details. Separate payment is not recommended.

2. The total recommended payment for the services in dispute is $5,654.72. The amount previously paid by the insurance carrier is $5,654.72, which leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 15, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.